National Emergency Medical Services Advisory Council

Meeting Summary

January 14–16, 2020

Department of Transportation
1200 New Jersey Ave. SE
Washington, DC 20590

Contents

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Meeting Summary

These minutes, submitted pursuant to the Federal Advisory Committee Act, are a summary of discussions that took place during the National Emergency Medical Services Advisory Council (NEMSAC) meeting on January 14–16, 2020. See Appendix A for a list of meeting participants.

Day 1: January 14, 2020

Call to Order and Introductions

Vincent Robbins, MS, and Jon Krohmer, MD

Mr. Robbins opened the meeting at 9:00 a.m. and welcomed NEMSAC members and other participants. He asked NEMSAC to observe a moment of silence in memory of Ed Gabriel, Principle Deputy Assistant Secretary for Preparedness and Response at the Department of Health and Human Services (HHS). Mr. Gabriel had died suddenly the previous week. NEMSAC members recalled Mr. Gabriel's many contributions to the emergency medical service (EMS) field.

Dr. Krohmer, the Designated Federal Official for this NEMSAC meeting, welcomed NEMSAC and other participants to this meeting on behalf of the Department of Transportation (DOT), Secretary of Transportation Chao, and the National Highway Traffic Safety Administration (NHTSA). He also announced that Nanda Srinavasan is the new Associate Administrator for research and program development at DOT. In addition, Lynn White, M.S., a NEMSAC member, received the Ronald. D. Stewart Award from the National Association of EMS Physicians in recognition of her lasting, major contribution to the national EMS community.

Dr. Krohmer asked NEMSAC members to identify conflicts of interest or potential conflicts of interest that have arisen since the September 17–19, 2019, NEMSAC meeting (see Appendix B). He also asked NEMSAC committees to provide advisories and other materials that needed to be printed well in advance of NEMSAC meetings. Ms. White suggested that the scheduling of future in-person committee meetings enable members to attend all meetings of the committees to which they belong. Mr. Robbins said that attempts will be made to minimize overlap between committee meetings.

Approval of September 17–19, 2019, NEMSAC Meeting Minutes

NEMSAC members requested the following changes to the draft minutes of NEMSAC's meeting on September 17–19, 2019:

- Correct the spelling of Ms. Montera's name on page 29.
- Correctly identify those who spoke at the meeting.

With these changes, NEMSAC approved a motion to accept the minutes of the September 17–19, 2019, NEMSAC meeting. Mr. Robbins suggested that future summaries of in-person NEMSAC meetings be more detailed.

Federal Liaison Update

Department of Transportation
Jon Krohmer, MD

The Office of EMS (OEMS) has published the 2019 update of its activities, and Dr. Krohmer hoped to fill open OEMS staff positions soon. The office recently published a request for information in the Federal Register to collect comments on the National Emergency Medical Services Information System (NEMSIS). OEMS staff will review these comments shortly.

In response to new federal cybersecurity regulations, OEMS will transfer NEMSIS from physical servers to a cloud environment and change the domain from ".org" to ".gov." Dr. Krohmer hoped to issue a request for proposals in the next few months for NEMSIS support activities. The contract with the University of Utah will end this year, and a full and open competition must be held to identify the next contractor.

Department of Homeland Security
Melissa Harvey, RN, MSPH

Gary Rasicot is the new Acting Assistant Secretary for the Countering Weapons of Mass Destruction Office of the Department of Homeland Security (DHS). The office is about to fill a vacancy for an EMS Program Manager, and four more EMS-related program officer positions will be posted soon. The office is rolling out a new electronic patient care reporting system.

The fiscal year 2020 congressional appropriations bill requires the DHS Chief Medical Officer to take on new coordination activities. For example, he will develop medical policy and guidance for all DHS operational departments that will allow emergency medical technicians (EMTs) to serve as EMTs in all department components. The bill also provides funds for the new DHS electronic medical record.

Department of Health and Human Services
Jonathan Greene

Many lessons learned from Hurricane Maria are being used to respond to the recent earthquakes in Puerto Rico. HHS is helping develop local answers to local problems in Puerto Rico. In addition, HHS is seeking candidates for the Hospital Preparedness Program (HPP) director.

Discussion

Mr. O'Neal noted the hurricane in Puerto Rico has caused shortages of intravenous (IV) fluid, and he asked whether a similar shortage is expected after the recent earthquakes. Mr. Greene said that many improvements have been made in the Puerto Rican infrastructure since the 2017

hurricane season. For example, more than 95% of electrical power has already been restored, and the IV fluid production on the island appears to be stable.

U.S. Fire Administration
Chief Richard Patrick

For the first time, the U.S. Fire Administration has adopted a mission statement and goals that include EMS. This mission is to support and strengthen fire and EMS systems and stakeholders to prepare for, prevent, mitigate, and respond to all hazards. The administration's goals include building a culture of preparedness in the fire and EMS systems and readying the nation's fire and EMS system for all hazards.

The U.S. Fire Administration collaborates with its federal colleagues through the Federal Interagency Committee on Emergency Medical Services (FICEMS), NEMSAC, and other interagency committees. The National Fire Academy provides several EMS-specific academic programs that are available to constituents at no cost. The agency is seeking a collaboration between NEMSIS and the agency's own reporting system because approximately 65% of the 28 million fire responses per year are EMS related.

Health Resources and Services Administration
Theresa Morrison-Quinata

On January 6, 2020, the National EMS for Children (EMSC) Data Analysis Resource Center of the Health Resources and Services Administration (HRSA) launched the second EMS agency assessment. The survey instrument was sent to approximately 11,000 EMS agencies and asks whether they have a pediatric emergency care coordinator and an established process for pediatric equipment skills checks. Ms. Morrison-Quinata will share preliminary results with NEMSAC at its April 2020 meeting. Ms. Morrison-Quinata asked NEMSAC to encourage EMS agencies to complete the assessment. She also noted that HRSA would like to transfer lessons learned from this assessment into the prehospital system.

In June 2020, Pediatric Readiness in the Emergency Department will launch its assessment, which will focus on the same elements as the previous assessment. Hospitals will be able to use the results to review trends over time and support quality improvement efforts.

Discussion

Dr. Fallat reported that less than 10% of EMS runs involve children, and children have often been discounted as a result of EMS activities. As a result, systems lack the skills needed to care for children, especially in rural and underserved areas. Forty percent of pediatric trauma and pediatric surgery patients enter the system through EMS or the emergency department (ED), and EMS practitioners must maintain the skills required to care for pediatric patients. In 2018, more than 80% of the 5,000 U.S. hospitals participated in the first Pediatric Readiness in the Emergency Department assessment, and Dr. Fallat hoped that the 2020 assessment would yield a similar or better response.

Mr. Powers said that improving the skills required to care for pediatric patients is important for emergency nurses. He asked whether the number of pediatric beds outside pediatric facilities is declining. Dr. Fallat said that even pediatric hospitals have challenges with bed availability, especially during influenza season.

Mr. Garrett asked whether the EMS agency assessment targets both transport and non-transport EMS agencies and what proportion of agencies have pediatric equipment. Ms. Morrison-Quinata replied that the agencies asked to respond are those that provide ground transport and respond to 911 calls, and the assessment is collecting data on recommended pediatric equipment.

U.S. Forest Service
Vivian Chen

The Forest Service's EMS Implementation Working Group is developing an EMS program for Forest Service employees, cooperators, and partner agency employees. This program will be based on the National Park Service's EMS program. Forest Service units will share a medical director with the National Park Service, a step that will save money for both agencies. The new policy will provide consistency in medical direction, standards, guidelines, and training across Forest Service field units. It will also provide consistency across agencies and facilitate interagency operability. This program has begun in two regions that have completed needs assessments.

Discussion

Dr. Fallat asked whether the needs assessments will address the ability to communicate in forests. Dr. Chen explained that the U.S. Forest Service has devices that can operate in each region.

Get Ahead of Stroke

Donald Frei, MD

Stroke is the fifth leading cause of death in the United States, and 140,000 people die of stroke every year. Because almost 2 million brain cells die every minute during a stroke, rapid treatment is necessary. Every hour of delay in treatment decreases the chance of a good outcome by 25%. Most strokes (87%) are ischemic, meaning that they are caused by a blood clot in the brain. The deadliest form is severe ischemic stroke with an emergent large-vessel occlusion (ELVO). ELVO develops in approximately 150,000 to 200,000 patients every year.

EMS practitioners can choose from many stroke severity scales that have good sensitivity and specificity, are easy to use, and can be completed in less than a minute. Their results can make a difference in where the patient needs to be taken for treatment. For example, EMS practitioners should transport patients who have probably had a stroke to a level 1 stroke center. They should also alert the stroke center that a patient is coming so that the ED and stroke teams can prepare for a rapid clinical and imaging assessment to select the appropriate treatment.

Thrombectomy is highly effective and increases life expectancy by 5 years in patients with LVO. The procedure is minimally invasive, but it should be completed before the patient loses too many neurons. However, only 15% of patients with LVO receive a thrombectomy each year. Most states lack protocols requiring first responders to transport patients with LVO to a level 1 stroke center, and no clear protocol ensures that patients with severe stroke are taken directly to such a stroke center. Furthermore, most hospitals are not level 1 stroke centers, and stroke severity is not routinely assessed in the field.

The goal of the Get Ahead of Stroke Campaign, an initiative of the Society of Neurointerventional Surgery, is to educate EMS professionals about assessment and triage in the field of patients with severe stroke. The campaign also works to drive policy change and public awareness, and it developed the Stroke Scales for EMS mobile app for EMS educators and providers.

Discussion

Ms. Knight asked how EMS practitioners should choose from among the stroke severity scales in the Stroke Scales for EMS app. Dr. Frei explained that all of the scales have been validated, and different jurisdictions use different ones. National guidance would be valuable on which scale to use.

Ms. White recommended that the Society of Neurointerventional Surgery develop guidelines on which scale to use because EMS providers would appreciate a recommendation from neurointerventionalists. Mr. Washko agreed and suggested that an evidence-based guideline group create a guideline and that the National EMS Quality Alliance then build measures for complying with the guidelines.

Mr. Washko asked about the use of mobile stroke units to determine whether a patient has LVO. Dr. Frei replied that mobile stroke units are costly to build and maintain, so they cannot help most patients. Mr. Powers suggested that a future NEMSAC meeting agenda include a report on the Stroke Treatment Delivered Using a Mobile Stroke Unit study.

Mr. O'Neal said that once stroke protocols are in place, legislation and marketing will be required to ensure that EMS providers are familiar with and implement the protocols. In addition, in rural areas, EMS providers might hesitate to take a patient to a level 1 stroke center if the drive takes several hours. Dr. Frei said that rural areas need different solutions, such as helicopter transport. Patients will not recover if they do not quickly reach a level 1 stroke center.

Ms. Lubogo asked about campaigns to educate the public about level 1 stroke centers and whether patients have the right to ask to be transported to a specific hospital. Dr. Frei replied that the Society of Neurointerventional Surgery is small and lacks resources for public education. Patients who maintain the ability to talk can ask to be taken to a specific facility. However, EMS teams usually have a strong mandate to take patients to the nearest hospital, and patients with aphasia cannot make requests.

Mr. Baird reported that one reason EMS systems are required to take patients to the closest hospital is that if an ambulance leaves the area, that vehicle is not available to transport other

patients. Furthermore, patients might need to be taken to a hospital that is affiliated with their coverage provider, they might want to go to the hospital they typically use for treatment of chronic conditions, and family members might want their loved one taken to a hospital that they can easily visit. To enable EMS providers to transport patients to level 1 stroke centers, legislation must mandate this practice and payers must cover the costs.

Dr. Frei explained that last known well time protocols are important for IV tissue-type plasminogen activator, but not for thrombectomy for LVO. Imaging is more important for determining whether a patient needs thrombectomy. Mr. Washko said that prehospital providers might not be aware of the need for imaging, rather than last known well time protocols, for patients needing thrombectomy.

An online participant asked about plans to collect data with the Stroke Scales for EMS app. Dr. Frei explained that the app cannot collect data.

Dr. Krohmer asked the NEMSAC Equitable Patient Care Committee to determine whether to develop an advisory on patients with stroke.

Safe Transport of Children

Dia Gainor, National Association of State EMS Officials (NASEMSO)

Ms. Montera, who chairs NEMSAC's Ad Hoc Committee on the Safe Transportation of Children, explained that the committee invited Ms. Gainor to provide needed background information. The committee will identify next steps after this presentation.

Ms. Gainor reported that approximately 1.6 million children younger than 14 years are transported in ambulances in the United States each year. Almost 30 products on the market are advertised as safely restraining children in ambulances. However, no federal regulations address child restraint in ambulances. In addition, conventional car seat manufacturers do not endorse the use of their car seats in ambulances, and no testing standard or requirement exists for child transport devices used in ambulances.

NASEMO proposes publication of three new standards by the Society of Automotive Engineering Standards International (SAE). SAE develops consensus test methods for ground vehicles, including the 10 ambulance-specific standards in current use. The three new standards will address requirements for supine and seated pediatric patients and for neonatal patients.

NASEMSO will form a committee with representatives of EMS agencies, testing laboratories, product manufacturers, ambulance builders, and government regulators. The committee will draft testing procedures, including component descriptions, patient positioning and weight, testing loads, which crash test dummies to use, and pass and fail criteria. If all the needed resources are available, the process will take 5 years. SAE will then evaluate the committee's design process using devices in a crash test laboratory that simulates the ambulance environment. The SAE review and publishing process will require another 1–2 years.

As NASEMSO refines plans for this process, it seeks the support and endorsement of national associations, industry, and government agencies.

Discussion

Ms. White asked whether the proposed process will address devices for transporting children by air. Ms. Gainor explained that assessing the safety of such devices is a natural next step once the standards are developed for ground transportation vehicles.

Ms. Gainor clarified that the first 10 SAE standards address the structural components of ambulances, and whether these standards should also cover portable devices needs to be determined. If these devices are not covered by the standards, states can use their own regulatory mechanisms to ensure the safe transportation of children.

Mr. Washko asked about using crash investigations to collect data on ambulance crashes. Mr. Bryson reported that these data will be shared with the committee that is developing the standards.

Ms. Montera asked how NEMSAC can move this effort forward. Ms. Gainor said that, ideally, NEMSAC would make the DOT Secretary aware of the issue and ask her to support this effort with expertise and resources. Dr. Krohmer explained that NEMSAC can issue an advisory to raise awareness of the issue, but this advisory would not address funding.

Mr. Baird asked whether the Food and Drug Administration (FDA) regulates child restraint devices in ambulances. Ms. Gainor said that FDA does not regulate these devices, but the agency should be aware of the issue and determine whether it has a role in approving these devices. Mr. Washko commented that whether these are medical devices or consumer products is not clear.

Mr. Robbins asked Ms. Montera and the Ad Hoc Committee on the Safe Transportation of Children to determine next steps on this topic.

FICEMS Strategic Plan Update

Kate Schwartzer

FICEMS released its previous 5-year strategic plan in December 2013, so it is time to develop a new strategic plan. The first step was to write a white paper that summarizes progress in implementing the goals and objectives of the previous plan, changes in EMS and 911 systems, and key considerations for the next strategic plan.

To draft the white paper, Ms. Schwartzer and her colleagues reviewed the literature, including FICEMS documents, reports (e.g., *EMS Agenda 2050* and *Beyond EMS Data Collection: Envision an Information-Driven Future for Emergency Medical Services*), FICEMS member and partner organization publications, and NEMSAC documents. The team also interviewed key stakeholders, including FICEMS and Technical Working Group members. FICEMS finalized the white paper in December 2019. In 2020, FICEMS will begin to develop its new strategic plan.

Public Comment

Mary Cameli, the Mesa, Arizona, fire chief, read aloud the following statement:

> I am here to speak in opposition of requiring higher education for paramedicine. I am familiar with the letter of opposition sent from the International Association of Fire Chiefs, International Association of Fire Fighters, the National Volunteer Fire Council, the National Fire Protection Association, and the Congressional Fire Services Institute. These five organizations make up the Steering Committee for the Fire Service-Based EMS Advocates Coalition that was formed in 2006. This coalition represents thousands of members throughout the country. The letter clearly states the position of the fire service-based EMS community and they strongly oppose this degree requirement that is under consideration. The fire service supports higher education and encourages members to take advantage of that. However, this requirement inflates the educational requirements for fire department paramedics and is not in the best interest of the nation's fire service. I am here today on behalf of Arizona Fire Services Institute which represents the Arizona Fire Chiefs Association, the Volunteer Firefighters of Arizona, the Arizona Fire Districts Association, and the Professional Firefighters of Arizona. Our position is clear—we strongly support what has been stated by our national fire service associations.
>
> As I indicated, this is an unnecessary requirement for paramedicine. There is no substantial evidence that indicates getting an undergraduate degree to become a paramedic makes a firefighter a better medic. Paramedicine is a specific skill set that focuses on the service delivery needs for effectively delivering emergency medicine. Arizona's fully accredited paramedic training and service delivery programs are strictly monitored and certified by the State—which has served as a functional and successful system for more than 50 years. Programs continue to be refined, kept current and are consistently re-evaluated to assure we continue to utilize best practices and skilled service. Requiring more classes to gain a degree in lieu of the certification lacks validation, is unnecessary and simply unsustainable. Volunteer and other small Fire Departments that serve rural areas work very hard to maintain the service delivery model we have today with paramedics and EMTs. The increased educational requirements will cause many departments, including municipalities, to reduce or eliminate their paramedic service because of the increased costs associated with training and education.
>
> This degree requirement is a not substantiated by evidenced-based data, and whether intended or not, would result in a reduction in the quality of emergency medical service and emergency response. In NEMSACs charter it states, and I will quote, "The Council's broad-based membership will ensure that it has sufficient EMS system expertise and geographic and demographic diversity to accurately reflect the EMS community as a whole. Members will be selected for their ability to represent sectors of the EMS community, but no member will represent a specific organization." This implies that a representative should not represent one Department's point of view and should be consistent with the position or opinion of a sector which has been clearly stated and submitted in writing. There are thousands Fire Departments across the United States who are the primary emergency medical providers for their communities and are making a difference in the lives of people every day. If service

levels are jeopardized by an unnecessary degree requirement, it will not be NEMSAC who is held responsible. It will be the Authority Having Jurisdiction that will be held accountable for the service levels and patient care. Implementing cosmetic educational or performance requirements is moving Fire Based EMS in a dangerous direction and it is the patients calling 911 who will pay the consequence of this requirement.

If this committee is under the impression or being told by anyone that the fire service as a whole supports this requirement, or opposes formal education within the fire service, this is a misrepresentation of a very clear position statement. I am appealing to the Fire Service-Based EMS representative(s) on this committee, as well as the other members, to hear and hopefully understand what the fire service is saying regarding this issue.

Thank you again for giving me the time to discuss this important matter with you. Once again, the Arizona Fire Services Institute, and the fire service as a whole, are not against education. There are numerous examples of just the opposite. But we strongly oppose an inflated and unjustifiable requirement that would undoubtedly cause many Fire Service organizations to eliminate critical programs due to funding. It will also reduce the number of individuals who would have the ability to acquire a paramedic certification because of the additional cost and additional time commitment.

Mr. Robbins said that NEMSAC is aware of the discussions on this topic in the fire service profession. This committee simply advises the Secretary of Transportation about the EMS profession, and it cannot establish regulations or requirements. Similarly, NHTSA does not have the authority to regulate educational requirements for practitioners; state legislations and professional boards make these decisions.

Mr. Tobin said that as the fire-based (career) EMS representative on NEMSAC, he is listening to input from the field. NEMSAC decided not to recommend requiring associate degrees for paramedics because of concerns from the fire-based community. The updated advisory does not recommend such a requirement.

Prehospital Pediatric Readiness

Kathleen Brown, MD

The goal of the National Pediatric Readiness Project is to ensure high-quality emergency care for all children. In a national self-assessment in 2013, which had an 83% response rate, participating hospitals received their own scores and the average scores of similar EDs and of all participating hospitals.

Another initiative that will begin soon is Pediatric Readiness in EMS Systems, which will ask EMS agencies whether they have a designated individual who coordinates pediatric emergency care and a requirement that EMS providers demonstrate the correct use of pediatric-specific equipment. The initiative will use the results of this assessment to develop pediatric readiness improvements and assess their impact.

Other activities of this initiative include publication of a policy and technical report in January 2020, development and dissemination of a checklist for EMS agencies to assess their compliance with the policy statement, and development of a toolkit of resources to improve agencies' pediatric readiness. An online survey will be administered in 2023, and improvement collaboratives will be formed in 2024 to help agencies improve their pediatric readiness scores.

Ongoing NHTSA Projects

Update of Field Triage Guidelines
Jon Krohmer, MD

OEMS is updating the guidelines for field triage of injured patients published by the Centers for Disease Control and Prevention (CDC) in 2012. An expert group is conducting a systematic review of the literature on triage and reviewing previous guidelines before proposing modifications to the field triage guidelines. The draft guidelines will then be presented to the community for review and feedback.

NEMSIS
Eric Chaney

As of December 2019, almost 50 million records were submitted to NEMSIS. OEMS continues to monitor NEMSIS data quality, which is improving. The NEMSIS public data queue has more than 63 million records available at no charge for quality improvement and research. Since 2006, almost 1,000 scholarly articles have been published on studies that used NEMSIS data.

The invitation-only National Pre-Hospital and Hospital Data Integration Listening Session Summit will be held in Washington, DC, on January 29, 2020. This meeting will identify the issues so that the OEMS can determine next steps. 911 and CDC Data Hub representatives will attend the meeting, and health information exchange and state efforts will be discussed.

National 911 Program
Kate Elkins, MPH

One of main tasks of the National 911 Program is to develop, collect, and disseminate information to implement 911 services. OEMS worked with the National Association of State 911 Administrators to write an annual progress report, published in November 2019, on the results of a survey. This survey of state and territorial 911 systems addressed current conditions and implementation of Next Generation 911. Data elements are being standardized to address the 911 data challenge, and the National 911 Program issues grants to states, tribes, and Washington, DC, to build infrastructure for the Next Generation 911 environment.

Discussion

Mr. Washko noted the lack of awareness of the important impact of 911 services on health care. Ms. Elkins agreed that the 911 system is behind EMS in development of infrastructure and capacity. Approximately 60% of 911 centers are sponsored by law-enforcement agencies, and

only one or two people answer calls in a large proportion of these services. The system's infrastructure needs to be developed to make the system bigger and better.

Revision of the National EMS Education Standards
David Bryson

A writing team is reviewing comments from various stakeholders as it develops the revised national EMS education standards and the accompanying instructional guidelines. Both drafts should be completed by early spring 2020, and the final versions should be available by the end of 2020.

Nomenclature Project
Jon Krohmer, MD

Several drafts of the deliberative process summary report have been issued for public comment, and the final draft would be delivered to the technical panel and stakeholder liaison groups on January 15, 2020. Contract staff will compile these reports and deliver them to OEMS in March, when the report will be shared with the community.

Video Recordings of EMS Practitioners
Jon Krohmer, MD

OEMS needs to do more to address concerns about videos taken by members of the public of EMS practitioners as they care for a patient in a home, on the street, or in an ambulance. Dr. Krohmer and his colleagues are trying to learn more about efforts in the law-enforcement community, and they will continue to gather other types of information.

Discussion

Dr. Krohmer clarified that the concern is not with recordings by EMS agencies but, rather, those by members of the community, such as family members or friends of the patient or bystanders. The question is how EMS agencies can prevent these recordings. Mr. Robbins added that NEMSAC's Integration and Technology Committee will decide whether to address this issue using the OEMS findings.

Mr. Washko suggested broadening this issue to include the capture and storage of digital information on EMS providers and patients, regardless of the source. Dr. Taillac pointed out that many trauma centers record resuscitations for review and quality improvement, and this practice is protected by quality improvement regulations. The videos are not available to the public or the press. Dr. Taillac agreed that guidelines for EMS video recordings for quality improvement purposes would be valuable. However, nothing can be done to stop members of the public from recording EMS activities in the field. Dr. Taillac suggested a survey of states to determine which ones protect audio and video recordings created for quality improvement purposes. Dr. Krohmer explained that OEMS can gather publicly available information, but it cannot conduct surveys without formal government review and approval.

Dr. Fallat said that in Kentucky, videos are discoverable for physicians. Videos are made for quality improvement and education, but they are destroyed after a month. Development of a policy that addresses videotaping and audiotaping and is applicable to every sector would be challenging. Before an advisory is developed, its purpose should be determined.

Mr. Robbins said that NEMSAC is interested in this issue. OEMS will continue to collect information that it will forward to the Integration and Technology Committee, which will discuss next steps.

Committee Reports

The chairs of NEMSAC's committees listed the advisories they planned to submit for interim or final approval on the last day of this meeting.

Ms. Montera planned to recommend that the Ad Hoc Committee on the Safe Transportation of Children draft a letter with recommendations to the Secretary of Transportation. The letter would ask the secretary to gather data on how to address this pressing need. Although the committee could develop an advisory, a letter will have the greatest impact because of the limited amount of empirical data to quantify the issue.

Day 1 Wrap-Up

Ms. Montera suggested that a few NEMSAC members try to reschedule the committee meetings on January 15 so that they do not overlap. Mr. Robbins said that this cannot be done for in-person meetings. Chairs and vice chairs need to attend their committee meetings, and other members can ask when a topic of interest will be discussed and join the meetings at those times.

Day 2: January 15, 2020

NEMSAC Chair and Vice-Chair Elections

Jon Krohmer, MD

The NEMSAC charter requires the council to elect a Chair and Vice Chair at the beginning of each year. Dr. Krohmer opened the table for nominations for Chair, and Mr. Robbins was nominated. Mr. Robbins accepted the nomination, and NEMSAC unanimously voted to elect Mr. Robbins for another term as NEMSAC Chair.

Dr. Krohmer then opened the table for nominations for Vice Chair, and Ms. Montera was nominated. She accepted the nomination, and NEMSAC unanimously voted to elect Ms. Montera for another term as NEMSAC Vice Chair.

National EMS Assessment and Evaluation of State Systems of Care for Time-Sensitive Emergencies

Dia Gainor, NASEMSO

Ms. Gainor described two tasks that she planned to present in more detail at NEMSAC's next in-person meeting.

The National EMS Assessment began in 2010 with a survey that asked states to answer 462 questions. Since that time, the number of questions has declined to make the assessment easier to complete. All 50 states; Washington, DC; and 2 territories participated in the assessment. The draft results have been shared with respondents, and some modifications are being made. Once the report is finalized, NASEMSO will share it with NEMSAC.

The second project is an evaluation of emerging state systems of care that focuses initially on stroke and ST-elevation myocardial infarction (STEMI) care. To date, 45 states have submitted their responses. The final deliverables are due in March, and Ms. Gainor hoped to present the results to NEMSAC in April 2020.

NEMSAC Biennial Report Review

Vincent Robbins, MS

Mr. Robbins asked NEMSAC to review the latest biennial report. Although the report is typically issued at the end of each council's 2-year term, this report is a bit late because of the time needed to stand up the current council.

Council members suggested the following corrections:

- Make sure that all NEMSAC member names are spelled correctly.
- Change the year for reorganization of the NEMSAC committee structure on page 3 to 2018.

A motion carried to approve the report as amended.

Dr. Taillac asked about efforts to add a law enforcement representative to NEMSAC. Dr. Krohmer explained that the NEMSAC positions are identified by statute, so he was not sure that a position could be added. Mr. Robbins suggested that NEMSAC explain in the report that it planned to consider whether to recommend that the secretary add a law-enforcement representative to the council.

Mr. Washko noted that NEMSAC had also suggested adding a payer representative, and he asked whether NEMSAC can add ad hoc members. Mr. Robbins explained that NEMSAC committees can call on subject matter experts for committee discussions, but NEMSAC does not have ad hoc members.

Ms. Lubogo recommended that the process for identifying new council members make sure that the new NEMSAC is diverse. Dr. Krohmer said that the secretary's office takes this need into account when it identifies members for all advisory committees.

Topics for Future Consideration by NEMSAC Committees

Vincent Robbins, MS

Dangerous Patient Behavior

At its September 2019 meeting, NEMSAC considered whether a committee should address dangerous patient behavior, including elopement from ambulances. Mr. Robbins asked whether this issue is still of interest to NEMSAC.

Mr. Washko reported that he had raised this issue, and he continued to advocate for NEMSAC to develop an advisory on the topic. Elopements are frequent and often result in injuries to patients or providers. Implementation of countermeasures is challenging because they must comply with vehicle specifications, regulations, and statutes while protecting patient rights. This issue arises most commonly with patients needing behavioral health interventions.

Mr. Emery agreed that NEMSAC should address this issue, which is a major challenge in American Indian/Alaska Native communities. Many jurisdictional challenges arise in transporting behavioral health patients from an Indian Health Service facility to another facility.

Ms. Montera pointed out that NEMSAC has an advisory on violence against EMS professionals, and she suggested that this advisory be broadened to discuss elopement. Mr. Powers explained that NEMSAC decided to focus that advisory on the safety of providers, not patients. Ms. White agreed that the two issues need to be addressed separately.

The Profession Safety Committee will consider developing an advisory on this topic. Mr. Washko and Mr. Emery volunteered to help draft this advisory. Mr. Robbins advised the committee that if it chooses to develop an advisory, it do so quickly because the current council will only meet in person twice more. However, if the committee cannot complete an advisory, the issue can be turned over to the new council to consider pursuing.

Ambulance Crash Investigations

Mr. Kaye reported that guidelines are needed on when and how to request an ambulance crash investigation. NEMSAC members agreed to develop an advisory on ambulance crash investigations, and Ms. Gainor offered to help draft the advisory.

Dr. Krohmer reported that NHTSA's crash investigators are not certain that NHTSA has the capacity to conduct crash investigations of ambulances. Furthermore, EMS agencies or their lawyers have sometimes prevented investigation teams from gaining access to the vehicle or speaking with personnel involved in an accident. If NHTSA commits resources, it must have this access. Finally, NHTSA does not have the legislative authority to mandate crash investigations for ambulances. Dr. Krohmer encouraged the committee to identify the purpose of ambulance crash investigations and how they might contribute to the discipline.

Mr. Kaye said that very few ambulance crashes have been investigated. A NEMSAC committee could ask NHTSA to develop guidelines indicating that investigation teams should ask whether the EMS agency involved will give them access to the relevant vehicle and personnel.

A motion carried to form an ad hoc committee to explore the development of an advisory on ambulance crash investigations. Mr. Washko agreed to chair this committee, which will include representatives of the Profession Safety and the Integration and Technology Committees.

Suggestions for this advisory were to recommend the following:

- Strategies to educate EMS agencies about the importance of giving crash investigators the access they require
- Protocol listing the requirements that must be in place before a crash investigation is requested
- Improvements in the collection of data on ambulance crashes
- Determination of types of data needed on ambulance crashes and how to report these data
- Use of these data to determine causes of ambulance crashes and ways to prevent them as well as to develop new ambulance safety training exercises or enhance existing ones
- Ways to overcome barriers to conducting ambulance crash investigations

NEMSAC recommended that the committee also do the following:

- Obtain ambulance crash data from Global Medical Response
- Ask insurance providers for their ambulance crash data
- Include Ms. Gainor and representatives of DOT's Office of Investigations and of siren centers as ad hoc committee members

Dr. Krohmer supported the idea of learning more about the data currently collected on ambulance crashes but said that this committee will need a more specific focus. The committee should not discuss the implications of crashes for vehicle standards because DOT does not have the authority to establish standards for ambulances.

EMS Agency Inclusion in Disaster Preparedness Training

Jonathan Greene

The Medical Response to Overwhelming No-Notice Trauma course is now offered at the Federal Emergency Management Administration (FEMA) Center for Domestic Preparedness in Aniston, Alabama. This course, provided at no cost to clinical care providers from treatment facilities, immerses participants into a simulated high-stress event. Participants provide realistic lifesaving emergency clinical care in a chaotic setting during and immediately after the event.

The course's development was prompted by discussions among responders to recent mass-casualty events, including the Boston Marathon bombing and the shootings at an Orlando nightclub and a Las Vegas outdoor concert. Collaborating partners are the office of the Assistant Secretary of HHS for Preparedness and Response (ASPR), FEMA, NHTSA, American College of Emergency Physicians, American College of Surgeons, and American Burn Association.

The course was originally designed to teach health care providers—especially trauma surgeons, emergency physicians, and nurses—how to quickly prepare the ED and move patients to operating rooms. Each course provides two scenarios that force participants to handle 200 victims per hour. The scenarios are being expanded to personnel from radiology, laboratory, blood bank, and other hospital units and will soon be extended to EMS personnel.

Discussion

Mr. Washko suggested that course participants develop disaster plans for transfer centers. Dr. Krohmer explained that this course focuses only on clinical care issues, such as rapid initial stabilization for catastrophically injured people, and does not address incident management or organizational structure. Mr. Greene suggested asking Richard Hunt, MD, a senior medical advisor for the National Health Care Preparedness Programs at ASPR, about transfer center disaster plans because such plans are relevant to ASPR.

Ms. Knight asked whether course participants receive orientation before being immersed in a scenario. Dr. Krohmer explained that the course offers intensive, hands-on experience and does not provide lessons on how to care for various types of injuries because participants already have those skills. The course does provide an orientation to the facility and its resources, and all injuries are simulated in ways that make them treatable.

Dr. Adelgais asked whether the course offers continuing education credits. Mr. Greene said that the plan is to provide such credits for all types of providers.

Dr. Fallat wondered whether the course could be offered to state teams of physicians, nurses, and EMS providers. Mr. Greene replied that the course is not designed to establish new teams in a region. However, the course developers plan to include EMS-specific skills, such as providing triage in an ED's ambulance bay or relieving compression in an ED by transferring some patients to other facilities. These skills could be transferred to a community once the training is complete. Whether communities can send teams to the course is not known, and a decision needs to be made about whether each course will be offered to individuals from around the country.

When asked about opportunities to observe the course, Dr. Krohmer explained that the number of observers must be limited to prevent their exposure to potentially dangerous conditions. Furthermore, NHTSA does not have funds to support NEMSAC member travel for this purpose. However, OEMS can determine whether NEMSAC members can observe the course if they are willing to pay their own way.

Hospital Preparedness Program

Jonathan Greene

The Hospital Preparedness Program (HPP) offers the only federal funding for regional health care system preparedness. HPP works to improve patient outcomes, minimize the need for supplemental state and federal resources during emergencies, and enable rapid recovery.

Between 2012 and 2016, HPP focused on developing health care system capabilities and capacity. HPP grants cooperative agreements to states, which distribute the funds to health care coalitions (HCCs). HCCs comprise health care and response organizations (e.g., hospitals, EMS agencies, emergency management organizations, public health agencies) in a defined geographic location, and they plan for and respond to disasters. In 2017, HCCs were required to include EMS agencies to receive funding because of the key role of EMS in disaster response.

Discussion

Mr. Greene explained that HCC does not include children's services. However, the National Disaster Medical System, which is separate from HCC, is developing pediatric disaster care centers of excellence to address pediatric care in emergencies, and two pilot projects will start soon. Mr. Greene offered to provide an update on this program at the next NEMSAC meeting.

Dr. Fallat argued that children need to be included in disaster preparedness planning. When disasters occur in schools, for example, plans are needed for transporting children who need care to pediatric centers and to ensure that EDs are ready to care for children. Mr. Greene pointed out that these issues are not specific to EMS. In addition, EMS and the traditional health care infrastructure were designed to be as efficient as possible, which is the opposite of what is required for surge capacity. The question is how health care and EMS systems can prepare to quickly shift gears during a surge without the ability to pay to make extra wards available all the time. For example, community hospitals could treat burns during a crisis, and EMS agencies might transfer patients to a different location or distribute patients during a national catastrophe.

Dr. Fallat said that the Preparedness and Education Committee's advisory on disaster preparedness is designed to make sure that people have access to the information they need during a disaster. She wondered how FICEMS and/or NHTSA could ensure that the needed information is conveyed between leaders and providers. Mr. Greene suggested that FICEMS work with HCC to address this need.

Dr. Adelgais reported that the Preparedness and Education Committee plans to call for more research, which could drive EMS engagement in disaster preparedness. Another recommendation might be to form a committee of public and private stakeholders to establish best practices. Mr. Greene noted that a great deal of activity is ongoing, but information on this activity is not shared across the enterprise. He suggested that the committee ask EMSC and HPP how to spread across the country the resources and knowledge these initiatives are developing.

Ms. Montera asked whether the advisory might recommend that HCCs have a certain percentage of EMS team members and that they document the dissemination of information to communities. Mr. Greene explained that the funding opportunity announcement for HPP has criteria for successful applications, and the basis for making awards is the extent to which applications meet those criteria. In 2017, some requirements were changed, and one change was to require EMS agencies to be active members of HCCs.

Public Comment

Cori Hayes, Assistant Fire Chief at Mesa, Arizona, Fire and Medical Department, said that she and her colleagues have concerns about the latest version of the advisory from the Preparedness and Education Committee on the transition of paramedics into a profession with formalized education and professional license to practice.

The Mesa Fire and Medical Department is cutting edge and is addressing almost every topic raised at this meeting. For example, every fire truck in the region has two paramedics and two EMTs. The department has been an industry leader in education, and it requires bachelor's degrees for battalion chiefs. However, the department does not require paramedics to have a bachelor's degree.

Ms. Hayes and her colleagues are concerned that the advisory's recommendations will limit her department's ability to provide EMS care. The department is unlikely to be able to offer tuition reimbursement for paramedics to obtain an associate degree. This requirement could turn the department into a basic life support agency, would not improve care, and would decrease the care available to the community. The requirement would be particularly debilitating in rural communities and others that rely on volunteer EMS organizations.

Mr. Robbins clarified that the advisory no longer recommends requiring a college degree for entry into the profession. A previous NEMSAC advisory did discuss advancing paramedicine through college education and advanced degrees, but the document noted that various sectors opposed mandating a minimum amount of college education for practitioners. The current advisory is based on the previous one, and it has softened earlier language recommending that states consider college degrees for entry-level paramedics.

Mr. Washko recommended that the Preparedness and Education Committee consult stakeholders (e.g., practitioners, EMS agency leaders) whose views might not have been considered. Mr. Robbins noted that the committee does have representatives of these groups.

Ms. Kaye pointed out that the EMS Agenda 2050, which was developed by stakeholders from throughout the EMS community, does call for degreed paramedics to support EMTs. Ms. Hayes added that paramedics in Arizona do obtain college credits. However, such a mandate would limit the department's ability to hire high-quality firefighters and would be an obstacle to increasing the profession's diversity.

Mr. Gale commented that although the recommendation to require an associate degree for entry-level paramedics was modified, some of the other language in the advisory implies that college degrees should be required. Mr. Baird agreed that the language throughout the advisory assumes that college degrees should be required, so it needs to be revised.

Mr. Powers suggested a separate advisory on recruitment and retention of EMS providers or a recommendation on this issue in the existing advisory. Ms. Lubogo explained that the committee discussed whether to recommend research on the impact of requiring a college degree on recruitment and retention, possibly through a survey by NHTSA for the EMS community. A

second potential recommendation is for NHTSA to evaluate outcomes in states that require college degrees for entry-level paramedics. Dr. Krohmer clarified that although NHTSA can conduct a survey, one of this magnitude would require review by DOT and the Office of Management and Budget, a process that would take at least a year. NHTSA would need to identify a source of funds for second type of study Ms. Lubogo had suggested and could not issue a new contract for this study until the next fiscal year, at the earliest.

Ms. Knight wondered whether some EMS agencies offer incentives for college degrees, just as some agencies do for speaking a foreign language. Mr. Garett said that some agencies do provide incentives for degrees.

Ed Racht, MD, the chief medical officer of Global Medical Response, said that education is valuable for decision making in the field. However, the draft advisory seems to assume that the ultimate goal is to require an associate or bachelor's degree for entering the EMS field. Dr. Racht asked whether such a requirement would enhance the EMS system by making it more clinically responsive, evidence influenced, and operationally sound.

Texas has both certified and licensed paramedics, and compensation, recruitment, and retention are similar for both types of providers. Some providers use college degrees to leave the EMS field and enter nursing or another health profession. Dr. Taillac said that a career ladder (e.g., from paramedic to advanced paramedic and then critical care paramedic) could prevent EMS practitioners from leaving EMS. Dr. Racht said that his company would embrace such a model.

Dr. Racht pointed out that education should focus on how to enable EMS practitioners to excel in their roles. The question is which provider level needs more education and credentials to navigate the new horizon of EMS. Mr. Washko said that college degrees are valuable for leaders and those who are responsible for quality improvement or training. However, the value of a college degree in clinical settings has yet to be established.

Mr. Robbins suggested that the Preparedness and Education Committee consider whether its recommendations have the appropriate specificity. The committee should also consider revising the narrative to avoid going beyond the recommendations, given the resulting confusion.

NEMSAC Committee Meetings

Each NEMSAC committee held a meeting to review the advisories the committee planned to present to NEMSAC the following day.

Day 3: January 16, 2020

Greeting from NHTSA's Acting Administrator

James. C. Owens, PhD, JD

Dr. Owens thanked NEMSAC for its continued efforts to identify national EMS and 911 issues. These efforts have improved the treatment of millions of citizens needing emergency care across the United States and its territories.

It is time to update the NEMSAC charter, and NHTSA has begun the update process. NHTSA has also begun the process of soliciting nominations, which Secretary Chao must approve, for new NEMSAC members.

At the Transportation Research Board annual meeting the previous day, Secretary Chao had announced the $38 million The First Responder Safety Technology Pilot Program to improve the safety of emergency response vehicles and personnel. The program will equip emergency response vehicles, transit vehicles, and highway infrastructure with vehicle-to-everything (V2X) technologies. These wireless technologies allow vehicles to share critical safety information with other road users and with highway infrastructure. When the technologies are applied to emergency response vehicles and traffic signaling infrastructure, they can help prevent tragic crashes and improve safety for vulnerable road users, including pedestrians and bicyclists.

V2X devices share information about a vehicle's location, speed, and direction. The devices let drivers know if another V2X-enabled vehicle is coming around a blind corner or if a pedestrian carrying a V2X device is in the roadway ahead.

The pilot program will gather safety data to foster collaboration among state and local government and private partners, test V2X technology integration, address an immediate safety need, and help speed up deployment in a technology-neutral manner. DOT will announce this funding opportunity in the next few weeks, and a webinar will educate first responders about how V2X technologies work and how they can help improve safety for first responders.

Discussion

Mr. McMichael asked about technology to protect animals during crashes. Dr. Owens replied that the department has issued for public comment some proposed test metrics for different crash-avoidance technologies, such as automatic emergency braking.

Mr. Garett asked whether the V2X technologies require 5G networks. Dr. Owens replied that cellular and dedicated short-range communication V2X technologies do not require 5G. The technology will work even in the absence of cellular service.

Community Response to Drug Overdose

Duane Caneva, MD, MS

Dr. Caneva shared a real-life example of an outbreak of overdoses resulting from fentanyl pills that buyers had believed contained Norco. The hospital that received the initial patient became overwhelmed as more patients with overdose symptoms arrived, and the hospital ran out of naloxone. Every bed in the hospital was quickly occupied. The hospital, which was a referral center in its region, had to start denying transfers, even for patients not experiencing an overdose. Similar incidents happen every day across the country.

The objectives of Community Response to Drug Overdose (CReDO) are as follows:

- Integrate medical, law enforcement, and drug prevention efforts for overdose clusters and spikes
- Improve community responses to the drug overdose crisis and the opioid public health emergency
- Align efforts across federal agencies and with state, local, and private partners
- Promote a system-of-systems architecture approach
- Identify and share best practices within communities

As part of CReDO, several resources are being established, including a national drug forensics registry, fusion centers, and regional poison control centers. DHS has asked the National Fire Protection Association's Standards Council to develop an American National Standards Institute–accredited standard. This standard would describe functions and actions related to the prevention of, preparedness for, response to, and recovery from drug overdoses by any community, authority having jurisdiction, facility, and/or organization that handles these types of incidents.

Discussion

Mr. O'Neal commented that EMS practitioners want real-time surveillance of opioid misuse to identify clusters of bad opioids. However, how to disseminate this information, whom to notify, and how to use the information need to be determined. Dr. Caneva explained that DHS is working to make RadResponder, an incident management tool that can share information, useful for CReDO responders. FEMA provides access to this tool at no charge, and it was developed for incident management by first responders.

Dr. Fallat stated that public health, social and family services, addiction management, and pain management are notoriously resource poor. Dr. Caneva explained that the Substance Abuse and Mental Health Services Administration is the lead agency for addiction management in urban areas, and the U.S. Department of Agriculture is the lead agency in rural areas. Social workers might be trained to provide EMS services.

Ms. Knight noted that her local fusion center has a medical liaison officer who communicates information quickly when needed to hospitals and other health-care centers. Dr. Caneva said that only a few fusion centers have a medical liaison officer, although DHS encourages fusion centers to appoint a public health or other health care professional.

Ms. Lubogo asked about education of the public about overdose prevention and what to do during a crisis. Dr. Caneva reported that each department or agency has its own program and its own measures of success, and these programs are not well coordinated. One goal of CReDO is to bring these programs together to optimize their efforts and resources and to develop harmonized messages.

Mr. Garett asked whether first responders can obtain access to social worker reports. Dr. Caneva explained that DHS started by identifying the problems and is now developing solutions. NEMSIS data can be useful, and tools in development will provide other needed information. Signals of a crisis need to be recognized quickly, within a few hours at most.

Mr. Washko asked about plans to distribute devices to first responders and whether CReDO might address real-time analyses and data sharing with the First Responder Resource Group, which focuses primarily on technologies used by fire departments, of the DHS Science and Technology Directorate. Dr. Caneva said that he would be happy to talk to any interested group about CReDO. He encouraged the First Responder Resource Group to consult the National Fire Protection Association's website and participate in the standards development process.

Applied Research and Technology at the U.S. Fire Administration

John Brasko, Fire Program Specialist, US Fire Administration

The National Fire Data Center conducts research to reduce firefighter line-of-duty fatalities and injuries; reduce civilian fire fatalities, injuries, and property loss; support the U.S. Fire Administration's EMS initiatives; and improve operational activities. The center also manages the National Fire Incident Reporting Systems, fire department registry, and firefighter on-duty fatality lists. Its research and development activities support fire detection, prevention, rescue, and suppression; improve firefighter and EMS responder health and safety; and reduce civilian deaths and injuries from fire. An emergency vehicle safety initiative offers targeted educational outreach, and a "slow down and move over" public service announcement enhances responder safety.

The U.S. Fire Administration conducts research on responder safety and health and has issued reports on such topics as violence to EMS responders. A study will address the impact of bright new LED emergency warning lights on drivers and ways to mitigate driver disorientation. In 2020, an EMS safety study will be updated. A FEMA-funded report describes the results of a literature review on mitigation of occupational violence to firefighters and EMS responders.

The National Emergency Training Center Library provides information and resources for fire, EMS, and emergency management. The National Fire Academy offers EMS-related management, operations, and safety courses on its campus, at local sites, and online.

Discussion

Mr. McMichael said that messages about slowing down and moving over need to be spread more broadly to protect the safety of emergency responders. Mr. Brasko noted that several agencies have posted this message on their websites.

Mr. Baird asked whether National Fire Academy courses are open to EMS providers who are not based in a fire department. Mr. Brasko said that personnel from any EMS agency may take these courses.

Public Comment

Dave Finger, Chief of Legislative and Regulatory Affairs at the National Volunteer Fire Council, thanked NEMSAC for addressing rural and volunteer EMS recruitment and retention in an advisory from the Adaptability and Innovation Committee. Mr. Finger had previously asked

NEMSAC to address this topic, and he appreciated the council's willingness to respond to his request. Recruitment and retention of volunteers in rural communities is a major problem. The advisory is well written, and the action items are feasible for NHTSA. The advisory will do a great deal of good for the people the council represents and raise the profile of NEMSAC and NHTSA with volunteer EMS practitioners.

Robert McClintock, Deputy Director of the Fire and EMS Operations Department at the International Association of Fire Fighters, thanked NEMSAC and NHTSA for their hard work to improve the EMS industry. Mr. McClintock had participated in the meeting the previous day of the Preparedness and Education Committee. His concern was not with education but with the elimination of a certificate for entry into the profession.

Pathways exist for people to enter the profession with a certificate or with an associate degree, and the International Association of Fire Fighters supports their ability to choose the best pathway for their needs. However, for many stakeholders, the endgame is to require a bachelor's degree to enter the field. The current shortage of paramedics would worsen if this requirement is implemented.

Ms. Lubogo noted that much of what Mr. McClintock had said in the previous day's committee meeting had resonated with the committee, which will try to address these points in its advisory. Because the advisory still requires work, it would not be presented for interim approval at this meeting.

Mr. Washko pointed out that no one has provided a reason for requiring bachelor's degrees for paramedics. Such a requirement would only be reasonable if it brings value to the profession.

George Hatch, Jr., reported that the Commission on Accreditation of Allied Health Education Programs has no position on whether paramedics should have an associate degree. The council has accredited almost 720 paramedic programs in all 50 states, and most programs are in universities and in community and technical colleges. These educational programs can offer college credit. Many education programs have very few participants, and some communities have ended paramedic programs that they cannot sustain. Most employers do not choose paramedics based on whether they have a college degree but, rather, of whether they have the required credentials.

Action on Proposed Advisories

Mr. Robbins, Ms. Montera, and Dr. Krohmer will spell out all acronyms when they edit the advisories after approval.

Sustainability and Efficiency Committee

EMS System Financing Advisory 2019 Update

Dr. Krohmer suggested that all the recommendations in this advisory be directed to FICEMS, not NHTSA. Mr. Baird, chair of the committee, agreed to make this change.

A motion carried to grant final approval to this advisory.

Integration and Technology Committee

Connected and Automated Vehicle Implications for Ambulances

Mr. Kaye will correct a typographical error on line 49, page 2, where "automated" should be "automatic."

A motion carried to grant final approval to this advisory.

NHTSA OEMS as the Central Repository for All EMS Provider Safety and Wellness Data

Mr. Robbins recommended that changing the sentence in Recommendation 2 (line 51, page 2) to "Every effort should be made to collect this data on an annual basis." NEMSAC cannot issue requirements because its mandate is only to make recommendations. Mr. Kaye agreed to make this change and to move the last two sentences in Recommendation 5 (lines 85–87, page 2) to the narrative.

Dr. Krohmer explained that NHTSA supports the recommendations in this advisory. However, he asked the committee to soften Recommendation 1 because, as written, it might be difficult to achieve. Mr. Kaye agreed to revise this sentence as follows: "The NEMSAC recommends that, to the extent possible, NHTSA should collect data from all federal agencies…" Mr. Kaye also stated that the committee might need to revisit Recommendation 2 once the ad hoc committee on ambulance crash investigations begins developing its advisory because this advisory could have implications for Recommendation 2.

A motion carried to grant final approval to this advisory.

Adaptability and Innovation Committee

Emergency Triage, Treat, and Transport (ET3) Model

Mr. Washko suggested adding "based on the value that the ET3 brings to CMS" at the end of Recommendation 1 (line 43, page 2). Mr. Gale agreed and suggested that the committee replace the word "increase" in this recommendation with a reference to value added.

Dr. Krohmer asked whether the activities in Recommendations 2 and 3 would be conducted after the pilot projects are completed. Mr. Gale said that the committee chose not to specify the timeframe for these activities, but Dr. Krohmer noted that Recommendations 1 and 4 imply that these activities might happen during the project. Although NEMSAC can make these recommendations, it should be aware that the Centers for Medicare & Medicaid Services (CMS) does not plan to make major changes to the reimbursement mechanism until the pilot project is completed. Mr. Gale said that the committee does not intend to recommend changes to the pilot project, and it would welcome suggestions to make this point clearer.

Ms. Montera and Mr. Robbins proposed changing the introductory text in the recommendations section (line 37, page 1) to "NEMSAC recommends that the Federal Interagency Committee on EMS (FICEMS), upon completion of the NHTSA pilot project or sooner if deemed appropriate by CMS…" so that this additional text applies to all four recommendations. Mr. Gale approved of this change.

A motion carried to grant final approval to this advisory.

Rural and Volunteer EMS Recruitment and Retention

Mr. Emery commented that this advisory addresses an important issue for both voluntary and paid EMS agencies. This issue must be addressed quickly because agencies are losing volunteer EMS providers every day, and communities have no providers to replace those who leave.

Dr. Taillac suggested replacing "successful providers" in the first two recommendations with "successful EMS agencies." Ms. Knight explained that the nomenclature requires the use of "provider" in this context. Mr. Robbins offered to take care of this issue during the editing process.

A motion carried to grant final approval to this advisory.

Telehealth as a Strategy for EMS Care

Mr. Washko helped write a paper that will be published in the *Annals of Emergency Medicine* on the distinction between telehealth and telemedicine and the impact on outcomes. He hoped that the advisory can cite this article because of its relevance.

Dr. Krohmer explained that AT&T has an exclusive contract to provide FirstNet capabilities. For the duration of this contract, FirstNet cannot work with other carriers. Discussions are ongoing between NHTSA and FirstNet about resulting concerns, especially in rural areas. Dr. Krohmer believes that at least one other large national carrier is developing a system that is similar to FirstNet but lacks preemption capability. Mr. Washko proposed modifying Recommendation 3 to address the shortcomings of existing technologies until FirstNet reaches rural communities. Mr. Robbins suggested eliminating "multiple cell phone carriers in" (line 53, page 2) from Recommendation 3, and Ms. Knight agreed.

A motion carried to grant interim approval to this draft advisory.

Profession Safety Committee

Mental Health and Wellness for the EMS Provider and Their Partners in Public Safety

Mr. Power noted that the wording needs to be altered so that it uses the glossary terms, and Mr. Robbins said that these changes will be made in the editing process.

A motion carried to grant final approval to this interim advisory.

Mitigation of Direct Violence Against EMS Professionals

Mr. Robbins suggested using the term "convene" in Recommendations 1 and 2 to make their language consistent with that of other advisories.

Dr. Krohmer asked whether the subcommittees mentioned in Recommendation 2 would be subcommittees of NEMSAC because NHTSA does not have subcommittees. Mr. Robbins explained that NEMSAC wants NHTSA to convene a group of subject matter experts after the proposed summit. These experts could be summit participants. Mr. Washko added that although the summit discussions might address the issues listed in the recommendation, this expert group would develop action items for NHTSA and FICEMS.

Mr. Robbins offered the following suggestions:

- Merge Recommendations 1 and 2:
    - Add a line at the end of Recommendation 1: "The summit should concentrate on at least the following items:"
    - Delete the text before the bullets in Recommendation 2.
    - Move the five bullets from Recommendation 2 to after the introductory sentence.
- In Recommendation 3, delete the text about monitoring the subcommittee's progress and simply state that the subcommittee will report to NEMSAC twice a year.

A motion carried to grant final approval to this interim advisory.

Preparedness and Education Committee

Pediatric Emergency Care Coordinator (PECC) for Emergency Medical Services

A motion carried to grant final approval to this interim advisory.

EMS Resource Allocation and Distribution During Disasters

Dr. Krohmer suggested that NEMSAC direct both recommendations to FICEMS in cooperation with ASPR, instead of to NHTSA and ASPR. ASPR has primary responsibility for preparedness and disaster response activities.

A motion carried to grant interim approval to this draft advisory.

Equitable Patient Care Committee

Reducing Social Inequities in EMS Through a National Out-of-Hospital Cardiac Arrest Registry

NEMSAC members offered the following suggestions:

- Indicate whether the advisory refers to cardiac arrest from all causes and in people of all ages

- Revise the first bullet (line 64, page 2) in Section C
- In Recommendation 4, specify whether the goal is to double the national survival rate or the survival rate of each EMS agency
- Add an explanation for the asterisk in Recommendation 3

Dr. Taillac asked why the advisory does not mention the Cardiac Arrest Registry to Enhance Survival, which collects data on approximately 40% of cardiac arrests in the United States. Mr. Robbins explained that NEMSAC cannot recommend use of a specific proprietary product, and Dr. Krohmer added that other prehospital registries of cardiac arrest exist.

Dr. Krohmer pointed out that this advisory addresses two separate issues: developing a prehospital cardiac arrest registry and improving national cardiac arrest outcomes. The title and most of the document imply that creating a registry will improve survival from cardiac arrest, but this link is indirect.

Mr. Robbins thought that, because of the amount of work still needed on this advisory, it is not ready for interim status. The Equitable Care Committee will therefore continue to revise the advisory and prepare it for interim approval at the next NEMSAC meeting. Mr. Robbins and Ms. Montera volunteered to help the committee make the needed revisions.

Next Steps

Mr. Kaye thanked Dr. Krohmer and the rest of the OEMS staff who provided the support that NEMSAC committees needed. Dr. Krohmer said that he is truly honored to work with the OEMS staff.

Dr. Krohmer instructed NEMSAC members that if they want to share materials for discussion at an in-person meeting, they must submit those materials at least one week before the meeting. This timeline will allow OEMS to send the material to a publisher, so that OEMS staff do not need to print and compile the documents.

Ms. Montera explained that NEMSAC committees use a single teleconference line for their calls, so only one committee can meet at a time. She suggested that the dates of committee meetings be posted in BaseCamp to ensure that they do not overlap.

Mr. Washko asked for an ET3 update at the next NEMSAC meeting. However, Dr. Krohmer reported that CMS might have no updates to share.

Dr. Krohmer explained once the Federal Register notice asking for NEMSAC nominations is published, the nomination and reappointment process will begin.

<u>911 Dispatch</u>

Ms. Lubogo asked whether, given that the terms of many NEMSAC members end in 6 months, the Preparedness and Education Committee should develop an advisory on 911 dispatch. Mr. Robbins explained that some NEMSAC members can be reappointed when the current term

ends. He suggested that the committees continue to work on their existing topics but give top priority to advisories that are ready for interim or final approval. NEMSAC members who are reappointed can continue to work on advisories begun during the current term. Dr. Krohmer added that NHTSA will plan a presentation at the April 2020 meeting on several 911 issues, including Next Generation 911, FirstNet, and emergency medical dispatching issues.

Loss of a License Because of a Felony

Mr. Powers suggested an agenda item on people who have several licenses (e.g., nursing and paramedicine) in different jurisdictions, lose one of these licenses in one jurisdiction because of a felony, but do not lose the other license in another jurisdiction. Mr. Robbins gave an example of a person who is a certified paramedic in New Jersey and a nurse in Pennsylvania. The nursing board takes action against the person in Pennsylvania, but this person can continue to work as a paramedic in Pennsylvania.

Before working on an advisory on this topic, NEMSAC needs to find out more about the federal government's role, if any, in this issue and which federal databases could be helpful for writing an advisory. A presentation could inform NEMSAC of resources that could be used to determine whether providers have had felony convictions in other states. Dr. Krohmer said that the Department of Justice only has jurisdiction over Drug Enforcement Administration licenses.

Human Trafficking

Ms. Knight suggested that NEMSAC consider an advisory on human trafficking because EMS practitioners have a unique opportunity to identify victims when they respond to calls. A NEMSAC advisory might, for example, recommend training for EMS personnel on the indicators of human trafficking. Mr. Emery said that human trafficking is an important issue in Indian country. Dr. Fallat agreed that this is a very topical issue that involves children and adults.

Dr. Krohmer said that although human trafficking is a major issue, developing an advisory on this topic might not be the best use of NEMSAC's time. Responses to human trafficking could benefit from better coordination, but NHTSA cannot provide this coordination. Dr. Krohmer agreed to arrange a presentation on this topic at the next NEMSAC meeting.

Mr. Robbins stated that NEMSAC cannot accomplish everything it would like to. However, if members believe that an issue is important, they should investigate the issue to determine whether they can contribute anything. Sometimes, the council finds that it has nothing to contribute but in other cases, NEMSAC can offer a valuable contribution. Ms. Knight will chair an ad hoc committee on human trafficking that will start by gathering information. NEMSAC will hear from experts at federal agencies, and the committee can then discuss whether it has time to work on this issue and what NEMSAC could contribute.

Dr. Adelgais volunteered to join the ad hoc committee. She also suggested that NEMSAC invite Jordan Greenbaum, MD, an expert on human trafficking, to speak to NEMSAC.

Mr. Robbins reminded NEMSAC members to keep NEMSAC's charge in mind as they consider new advisories.

Summary of Potential Future Agenda Topics

In summary, agenda topics suggested during this meeting for the April or August NEMSAC meetings were as follows:

- Next Generation 911, FirstNet, and emergency medical dispatching issues
- Report card on the status of NEMSAC's activities over the past 4 years
- ET3 update from CMS
- Federal resources that could be used to identify individuals who have lost a provider (e.g., paramedic) license in one state because of a felony but maintain a different type of license (e.g., nursing or EMT) in another state
- The January 29, 2020, data integration meeting
- Human trafficking
- Stroke Treatment Delivered Using a Mobile Stroke Unit study
- National EMS assessment and evaluation of emerging state systems of care (from NASEMSO)
- Pediatric disaster care centers of excellence of the National Disaster Medical System (from Mr. Greene)

Adjourn

A motion carried to adjourn the meeting at 1:03 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

August 19, 2020

Vince Robbins, Chair, NEMSAC — Date

These minutes will be considered formally for approval by the council at its next meeting. Any corrections or insertions will be made in the minutes at that time.

Appendix A: Participants

National Emergency Medical Services Advisory Council Members in Attendance and Their Sectors

*Kathleen Adelgais, MD
Pediatric Emergency Physicians
Golden, CO

Mary Ahlers, Med, BSN
EMS Educators
Cincinnati, OH

Shawn Baird, MA
Private EMS
Portland, OR

Eric Emery
Tribal EMS
Rosebud, SD

Mary Fallat, MD
Trauma Surgeons
Louisville, KY

Val Gale, MS
Local EMS Service Directors/Administrators
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Appendix B: Conflicts of Interest

NEMSAC members disclosed the following new real, potential, or perceived conflicts of interest:

- Ms. White: Board member, National Association of EMS Physicians; advisory committee member, Cardiac Arrest Registry to Enhance Survival
- Mr. Washko: Board member, National EMS Quality Alliance

No other NEMSAC member reported a new conflict of interest or potential conflict of interest.